A. Project Overview

Public Consulting Group (PCG) was contracted by the Alabama Medicaid Agency (ALMA) to complete a Medicaid payment reconciliation project for supplemental payments made to eligible teaching physicians. In 2005 ALMA implemented enhanced rates to teaching physicians, as well as aggregate increases to all physicians to improve access to services to Medicaid recipients. These enhanced rates were funded with state dollars provided by the public provider system including state affiliated teaching facilities, specifically the University of Alabama at Birmingham, the University of South Alabama, and the Children's Health System. The state share Intergovernmental Transfer (IGT) amounts were based upon Medicaid utilization projections, not actual Medicaid volume. ALMA requested that PCG reconcile the actual payments made under the enhanced rates to ensure sufficient state funding has been provided to fund the payment enhancements and that there have been no overpayments.

PCG began the reconciliation exercise by aggregating MMIS payments and volume by physician group Medicaid billing numbers. This allowed PCG to aggregate the payments and volume by the various physician practice plans that qualify for the enhanced payment rates. PCG verified that only physician services were included in our Medicaid volume and payment summaries. However, there are data elements within the MMIS, such as modifiers, that are often used to differentiate who rendered the service. PCG sifted through MMIS data in order to fully understand all service indicators and capture only relevant data for the reconciliation efforts. PCG also accounted for different payment methodologies to ensure the total volume reported accurately represents the volume of services provided by a physician practice plan.

After completing the aggregation of all Medicaid volume for the time period of this reconciliation, PCG completed a summary variance analysis comparing actual volume to the

projected Medicaid volume used for the state share IGT amounts transferred by the eligible public physician practice plans. PCG summarized the variance analyses by federal fiscal year. Based upon the variances of the actual Medicaid utilization compared to the Medicaid projections, PCG calculated whether additional state share funding is required based upon the results of our calculations. PCG also determined if state dollars transferred to date exceeded the required funds to draw down the additional federal dollars to fund the enhanced payment rates, resulting in a payback situation. PCG identified the appropriate Federal Medical Assistance Percentage (FMAP) to determine the additional state dollars required to sufficiently fund the enhanced physician payment rates. PCG aggregated these results by physician group practice plan.

Definitions

Procedure Code-Type of Service – a grouping of all unique instances of a particular procedure code and type of service which has a unique payment rate

Unique MMIS Claim – An unedited individual line item claim within the MMIS data provided by ALMA

Unique Claim Grouping – A set of MMIS information that has been grouped uniquely by procedure code, type of service, modifier 1, modifier 2, and Payment Rate Per Item Billed.

Payment Rate Per Item Billed – On a Unique MMIS Claim, the division of Paid Amount by Quantity Billed.

B. DATA AGGREGATION

MMIS Data

For the reconciliation, ALMA sent PCG Medicaid utilization for DOS 2/1/05 – 9/30/06. The data provided for DOS 2/1/05 – 9/30/2005 was only provided for university billing providers and was broken out by date of service. The data for paid dates 10/1/2005 – 12/31/2005 was provided in the file for both university billing providers and community providers, and broken out by payment date. The data for paid dates 1/1/2006 -12/31/2007 was provided in 24 monthly paid claim files broken out by payment date. All utilization for dates of service prior to 10/1/2005 was removed from the paid claim files for October 2005 – December 2007 in order to prevent duplicative claims from DOS claim file for February 2005-September 2005. In addition, while community provider utilization was included for DOS 10/1/05 – 12/31/05, it was not included in the reconciliation because the services were provided prior to the effective date of the Community Enhanced Rates as of 1/1/2006. While university providers were allowed to be reimbursed at enhanced rates for the retroactive period 2/1/2005-12/31/2005, community providers were not allowed to claim retroactive to 1/1/2006 with the Community Enhanced Rates.

Claim Grouping

In order to accurately apply the correct rates for each Unique MMIS Claim, it was important to aggregate the MMIS data provided by ALMA into dates of service. Each Unique MMIS Claim was broken out by the beginning date of service and then grouped into the appropriate quarter of the federal fiscal years 2005 and 2006. This methodology was followed for all paid claims files. Despite the different manner in which PCG received claims information for the FFY 2005 and 2006, there was no risk of including the same claim twice as the paid date files did not include

any services provided in the FFY 2005. ALMA had already broken out the FFY 2005 data by data of service and PCG simply broke the information into the FFY 2005 Quarter 2 (2/1/2005-3/31/2005), Quarter 3 (4/1/2005-6/30/2005), and Quarter 4 (7/1/2005-9/30/2005). PCG continued the analysis by breaking out the paid dates files for 1/1/2006-12/31/2007 into date of service quarters for the four quarters of the FFY 2006. For example, the January 2006 paid claims data was broken out into Federal Fiscal Year 2006 Quarter 1 (DOS 10/1/2005-12/31/2005) and Federal Fiscal Year 2006 Quarter 2 (for this file, only including DOS 1/1/2006-1/31/2006). Once all MMIS claims files had been broken out into DOS for the three quarters of FFY 2005 and the four quarters of FFY 2006, these files were then appended together to create master files by date of service for each of the seven quarters for this reconciliation. All append tables were reconciled to ensure that no files were left out of the master tables by date of service.

Values Created for Reconciliation

PCG added several terms to the DOS quarterly master files in order to properly account for the data that was given.

- "Absolute Value of Quantity Billed" - The absolute value of the quantity billed for each Unique MMIS Claim. The use of this value allows for the multiplication of quantity billed by the negative payment values without reversing the negative sign to positive. All PCG analysis utilized the "Absolute Value of Quantity Billed" rather than "Quantity Billed".
- "Anes [anesthesia] Count Conversion" – Converts quantity billed for anesthesia procedure codes into a value that could be multiplied by the relative-value unit and payment rate for a procedure code in order to project non-modified payments rates (payment at 100% of rate). Specifically, as anesthesia quantity is calculated in time

increments of fifteen, "Anes Count" Conversion" simply changed the value in the quantity billed column of each Unique MMIS Claim to match the group of fifteen it represented. Thusly, any anesthesia codes with a Unique MMIS Claim quantity billed between: 1-15 was changed to 1; 16-30 was changed to 2; 31-45 was changed to 3; 46-60 was changed to 4; etc. The calculation of anesthesia codes is described further in the **Reconciliation Methodology - Anesthesia Procedure Code Services** section of this report.

- "Old" and "Enhanced" rate – These rates were added to each Unique MMIS Claim based upon its Procedure code-Type of Service. For a description of PCG's rate sheet development, please see **Rate Sheet Development**.

Rate Sheet Development

The university providers were given enhanced rates that were exclusive to their providers, while the community providers had a different set of enhanced rates. Prior to the enhancement on 1/1/2006, Medicaid paid all University and Community claims with the same rates. After the enhancement, University rates were paid under a different reimbursement system than the Community rates. The enhanced rates were implemented for DOS beginning 1/1/2006 and were effective for university and community providers on and after that date. However, university providers were allowed to be reimbursed with the enhanced rates for a retroactive period from 2/1/05 – 12/31/05. Community providers were not afforded the opportunity to be reimbursed retroactively under the enhanced rates.

The paramount sources of the rates PCG used in our reconciliation analysis were complete rate sheets provided by ALMA listing procedure code, type of service, rate, and beginning date of the

rate. This was provided for old rates (rates implemented prior to 12/31/2005) and for enhanced rates (rates implemented as of 1/1/2006). PCG developed rate sheets for the Universities and the Communities separately, as they have different pay structures as a result of the enhancement. "Enhanced Rates" provided by ALMA were cross-referenced to remove any rates that increased after 1/1/2006 through a medium other than the Physician UPL Enhancement (i.e., CMS quarterly updates).

When there were two or more rates for a given procedure code within either university or community rates, the rate with the latest beginning date was used. PCG crosswalked our rate sheets with the rates shown in other sources provided by ALMA in order to ensure there were no missing rates or discrepancies between sources. The result was three comprehensive rate sheets: a rate sheet entitled "University Enhanced Rates" for university providers on or after 1/1/2006; a rate sheet entitled "Community Enhanced Rates" for the community providers on or after 1/1/2006; and a rate sheet entitled "Old Rates" for both the universities and communities for DOS on or before 12/31/2006. These will be referred to throughout the report as "University Enhanced Rates", "Community Enhanced Rates", and "Old Rates" and can be found on the **Support CD – Reconciliation Databases** provided with the Final Report.

Utilization Excluded From the Reconciliation

All Procedure Code-Type of Service's for which an old rate, an enhanced rate, or both rates were unavailable were removed from the reconciliation under the presumption that a missing rate was in fact a "non-existent" rate. An example of a non-existent rate is a Procedure-Code-Type of Service that has a rate prior to 12/31/05 (old rate), but no rate that was implemented on or after 1/1/2006 (enhanced rate). This is clearly just a procedure code that was not enhanced through the

UPL process and should not affect the final amount due that is determined through this reconciliation project. Those Procedure Code-Type of Service's that had a rate implemented on or after 1/1/2006, but no rate prior to that date, were removed because there is no "old rate" floor from which to compare the enhanced rate. Regardless, many rates like this are simply new procedure codes that were implemented after 1/1/2006. In order to determine Procedure Code-Type of Service's with missing rates, PCG compared the comprehensive rate sheets it developed to an aggregation of all Procedure Code-Type of Service's shown within all MMIS data provided for DOS 2/1/2005-9/30/2006. Any Procedure Code-Type of Service's that were found in the MMIS data, but for which there was a missing rate, were sent to ALMA in the following six groups for their review:

- University MMIS Utilization - Procedure Codes with No Rate on or Before 12/31/2005
- University MMIS Utilization - Procedure Codes with No Rate Increase on 1/1/2006
- University MMIS Utilization - Procedure Codes with No Corresponding Rates
- Community MMIS Utilization - Procedure Codes with No Rate On or Before 12/31/2005
- Community MMIS Utilization - Procedure Codes with No Rate Increase on 1/1/2006
- Community MMIS Utilization - Procedure Codes with No Corresponding Rates

ALMA verified that all the Procedure Codes-Type of Service's that had "missing" rates were in fact non-existent rates and were thusly not to be included in the reconciliation. All Unique Claim Grouping's for which there was either a missing old rate, a missing enhanced rate, or neither rate was available were removed from the reconciliation and aggregated for review on the CD entitled **Support CD – Reconciliation Databases** of the Final Report.

Additionally, PCG removed procedure codes for certain services which ALMA deemed were not to be included in the UPL enhancement. For claims submitted by university providers, the services that were earmarked for exclusion from the UPL enhancement were:

- Drugs - procedure codes #J0000-J9999

For claims submitted by community providers, the services that were earmarked for exclusion from the UPL enhancement were:

- Immune Globulins - procedure codes #90281-90399
- Immunization Administration - procedure codes #90465-90474
- Vaccines, Toxiods – procedure codes #90476-90749
- Drugs – procedure codes #J0000-J9999
- Temporary Codes – #Q0000-Q0999
- Temporary National Codes – #S0000-S9999
- Deliveries - #59000-59622
- End Stage Renal Disease Services – #90918-90925
- All codes that begin with an Alphanumeric character
- All utilization with Type of Service S

The utilization for any Procedure Code-Type of Service's that were removed from the reconciliation as not part of the rate enhancement has been aggregated for review and can be found on the CD entitled **Support CD – Reconciliation Databases** of the Final Report under the following titles:

- Removed Procedure Codes - University
- Removed Procedure Codes - Community

C RECONCILIATION METHODOLGY

Universal Reconciliation Methodology

The following section explains PCG's universal approach to payment reconciliation for all service types. Later in this report, we have detailed subtleties that were accounted for when dealing with specific service types.

Once the MMIS data had been aggregated into date of service quarters and comprehensive rate sheets had been developed, PCG was prepared to synthesize the data in order to complete the reconciliation. PCG's methodology was to use the payment from the MMIS data as a base and then to project what the payment would have been under a rate that was not used during that time

period. Throughout the analysis, the payment rate that was valid (on the date the claim was paid) for the specific date of service of each Unique MMIS claim is referred to as the "prevailing rate". For DOS prior to 1/1/2006, the prevailing rate in the actual MMIS payment was the old rates. Within PCG's analysis, these values are referred to as "actual payments". PCG then projected what the payment would have been under an enhanced rate, the "projected payment". The gap between what the actual payment was and what the projected payment would have been is the amount of increased payment as a result of the enhancement. This amount represents the increased payment "gap" for which the universities have agreed to pay the state share. For dates of service on or after 1/1/2006, when the enhanced rates were made active, actual payments were made at the enhanced rate. As a result, while PCG was able to use the same universal reconciliation methodology, the process had to be reversed. In order to determine the increased payment "gap", PCG projected back to what the payment would have been using the old rates. The difference between the actual payments under the enhanced rates and the projected payments under the old rates is the responsibility of the university providers.

The following sections are short narratives that walk through the calculations for non-anesthesia procedure codes and anesthesia codes. Each has been prepared from dates of service prior to 1/1/2006, meaning that the prevailing rate at the time was the old rate. All calculations used the prevailing rate that was in effect at the time the service was provided and projects what the payment would have been under the rate structure that was not in affect when that service was provided. In these examples, the old rate is the prevailing rate and PCG projected what the payment would have been under the enhanced rate structure. For dates of service on or after 1/1/2006, the process was reversed. PCG has provided additional hard copy examples of both university and community calculations in the **University Summary** and **Community Summary**

tabs of the Final Report. For a complete listing of all calculations, please see the CD entitled **Support CD – Reconciliation Databases**.

Non-Anesthesia Procedure Code Services

The following section describes how the Universal Reconciliation Methodology was applied to Procedure Code-Type of Services for non-anesthesia services. PCG's methodology was to group all Unique MMIS Claims by procedure code, type of service, modifier 1, modifier 2, claim type, and Payment Rate Per Item Billed. Payment Rate Per Item Billed was necessary because many Unique MMIS Claims had a quantity greater than one and thusly showed payment for more than one service provided. However, in order to compare the actual payment to the prevailing rate, it is necessary to determine how much was paid on a per item basis. In general, Payment Rate Per Item Billed value should match the prevailing rate for that particular Procedure Code-Type of Service at the time the service was provided. However, modifiers and Pricing Action Codes (PACs) can impact the percentage of the prevailing rate that is paid on a particular claim. PCG accounted for this by grouping by both modifiers and Payment Rate Per Item Billed. After identifying a discrete Unique MMIS Claim actual payment rate and comparing this rate to the prevailing rate, PCG was able to identify the percentage of the prevailing rate that ALMA had paid on that specific Procedure Code-Type of Service. This was key because PCG used the percentage of the prevailing rate that was paid and multiplied this percentage by the rate we were projecting to in order to determine what the payment would have been under the different rate structure. Examples of the non-anesthesia procedure code methodology are detailed on the following pages:

Procedure Code	TOS	Mod1	Mod2	SumOf Absolute Val of Quan Billed	Actual Pmt Rate Per Item Billed	Actual SumOf Paid Amount	Old Rates	Actual Pmt Rate as % of Old Rate	Enhanced Rates	Claim Type	Actual Pmt Rate at Enhanced Rate	Payment Increase
10022	2			1	$6.74	$6.74	$58.00	11.62%	$179.00	E	$20.80	$14.06
10022	2			3	$29.00	$87.00	$58.00	50.00%	$179.00	J	$268.50	$181.50
10022	2			6	$58.00	$348.00	$58.00	100.00%	$179.00	J	$1,074.00	$726.00

Non-Anesthesia Procedure Codes – Example Calculation Walkthrough

In the example above, the third line item is the most straight forward example of PCG's methodology for non-anesthesia procedure codes. The Unique MMIS claim had a total paid amount of $348.00 and a quantity of 6, resulting in a Payment Rate Per Item Billed of $58.00. The prevailing rate in the example is the old rate, which for this Procedure Code-Type of Service is $58.00. As a result, the Actual Payment Rate as a % of the Old [prevailing] Rate is 100%. PCG then applied this percentage to the rate we were projecting to, the enhanced rate of $179.00. As a result, the Actual Payment Rate at Enhanced Rate was $179.00 * 100% * 6 (quantity billed), which equals $1,074. The Payment Increase as a result of the enhancement is the difference between the Actual Payment Rate at Enhanced Rate and the Actual Sum of Paid Amount, $1,074.00 - $348.00 = $726.00. For this particular line item, the university providers realized a payment increase of $726.00 as a result of the enhancement and will be responsible for the state share of this increase.

Comparing the first, second, and third line items demonstrates another important aspect of our methodology. Specifically, line items 1, 2, and 3 all have the exact same procedure code, type of service, modifier 1 and modifier 2, but they have been grouped separately. These line items were grouped separately because they had a different Payment Rate Per Item Billed. As discussed in the previous paragraph, the third line item had an actual payment that was at 100% of the prevailing rate at the time these services were provided. While all three line items have the same

prevailing rate, $58.00, they were paid differently. Line items 2 and 3 paid less than 100% of the prevailing rate, 11.62% and 50% respectively. The reason that line item 1 was paid differently than line 2 and 3 is made clear by looking at the Claim Type column. Line 1 has a Claim Type of E, which indicates that this Unique MMIS Claim was for a Medicaid crossover claim. PCG applied the same methodology to crossover claims that was used to project payments for Medicaid as primary payer claims, projecting payment based upon the percentage of the prevailing rate that was paid on the actual payment. For line item 1, the percentage of the prevailing rate that was paid was only 11.62%. The difference between line items 2 and 3 is, again, that they were paid at a different Payment Rate Per Item Billed. This is presumably due to a Pricing Action Code, which can affect payment rates in a manner similar to how modifiers change the payment rate on a Procedure Code-Type of Service.

Anesthesia Procedure Code Services

The following section describes how the Universal Reconciliation Methodology was applied to Procedure Code-Type of Services for anesthesia services. PCG used the same methodology for payments associated with anesthesia services as with other procedure codes. Namely, all utilization was grouped by procedure code, type of service, modifier 1, modifier 2, claim type, and payment rate per item billed. However, given the abnormal way in which anesthesia quantity is calculated, it was important to adapt the information that was plugged into this methodology to ensure that all calculations were accurate portrayals of the manner in which anesthesia claims are paid. PCG did not use Payment Rate Per Item Billed on anesthesia calculations because the quantity value is not paid in a uniform manner. Instead, PCG used the following calculation in order to calculate expected anesthesia payment and compare it to the percent at which actual payments were paid with the prevailing rate at that time.

(Count of Procedure Code(RVU*Rate)) + (Sum of Anes Count*Rate) = Expected Full Payment*

Prior to grouping all data by procedure code, type of service, claim type, modifier 1, modifier 2, and payment rate in our final export analysis, PCG needed to know how many individual occurrences there were for each procedure code because the starting point for any anesthesia payment is based upon the RVU. By counting the number of occurrences for each procedure code and then multiplying the sum of this count by the RVU for that particular rate, PCG was able to determine the "starting point" for each anesthesia payment. To this "starting point" for each expected anesthesia payment, PCG also must add a multiplier of the rate for that Procedure Code-Type of Service based upon the total quantity billed. However, it was important that PCG account for the fact that this multiplier increases with each group of fifteen shown as a quantity billed, not for each individual quantity of one billed. For example, if a procedure code had a sum of quantity billed of 2, this would be paid at exactly the same expected payment as the same procedure code with a sum of quantity of 13. In fact, all sums of quantity billed for that procedure code ranging from 1-15 will pay exactly the same, 1*Rate. However, if the sum of quantity billed ranges from 16-30, its expected payment would increase by 2*Rate for that procedure code-type of service combination.

With these adaptations put into our basic methodology, PCG could now calculate a true expected payment rate for each anesthesia Procedure Code-Type of Service. As with other rates, actual payment from MMIS was summed for all enhanced rates for each quarter. For all quarters prior to 1/1/2006, these actual payments were made at the "old rate" and used as the base to which any projected payments made under an enhanced rate would be compared for reconciliation purposes.

PCG then compared the actual payment amount to an expected payment rate under the "old rates" to calculate the percent of the expected rate which was paid while under the old rate methodology. The expected payment rate was then calculated for the enhanced rate and multiplied by the percent paid under the old rate system, resulting in an expected payment rate that can be compared back to the actual MMIS payment (under the old rates) to calculate the total Payment Increase for each grouped Procedure Code-Type of Service for the reconciliation. For quarters 1-3 of FFY 2006, the actual MMIS payments were deemed the payments under the enhanced rates and PCG projected the "old rates". An example of the anesthesia procedure code methodology is detailed on the following pages:

Procedure Code	Count Of Procedure Code	TOS	Mod1	Mod2	Sum Of Absolute Val of Quan Billed	Sum Of Anes Count Conv	Actual Sum Of Paid Amount	Old Rates	Enhanced Rates	Claim Type	RVU	Actual Anes Paid Rate	Anes Actual Pmt Rate as % of Old Rate	Actual Anes Paid Rate at Enhanced Rate	Anes Actual Pmt Rate at Enhanced Rate	Payment Increase
00103	1	7	AA		73	5	$112.40	$11.24	$23.00	J	5	$112.40	100.00%	$230.00	$230.00	$117.60
00103	1	7	QK		54	(4)	($50.58)	$11.24	$23.00	J	5	($101.16)	50.00%	($207.00)	($103.50)	($52.92)
00103	1	7	QK		101	7	$67.44	$11.24	$23.00	J	5	$134.88	50.00%	$276.00	$138.00	$70.56

Non-Anesthesia Procedure Codes - Example Calculation Walkthrough

In the example above, line item 1 can be followed using the equation for anesthesia procedure code payment from earlier in this section. Line item 1 had a Count of Procedure Code of 1, meaning that this Procedure Code-Type of Service only occurred once in this quarter. So the left side of the equation is 1 * (5 [RVU for this Procedure-Code-Type of Service] * 11.24 [prevailing rate]). The right side of the equation is the sum of the Anesthesia Count [see **Definitions**] * the Prevailing Rate. Adding the two parts of the equation together, line 1's actual expected payment is created by the following equation:

(1(5*11.24)) + (5*11.24) = $112.40*

(Count of Procedure Code(RVU*Rate)) + (Sum of Anes Count*Rate) = Expected Full Payment*

The Expected Full Payment is then compared to the Sum of Actual Payment to determine the percentage of the prevailing rate that was actually paid. On line 1, this is $112.40/$112.40, meaning that the actual payment was made at 100% of the prevailing rate. PCG then used the same equation as above to calculate the Actual Anesthesia Paid Rate at Enhanced Rate [$23.00]:

(1(5*23.00)) + (5*23.00) = $230.00*

(Count of Procedure Code(RVU*Rate)) + (Sum of Anes Count*Rate) = Expected Full Payment*

The Expected Full Payment under the enhanced rate was then applied to the percentage of actual payment under the prevailing rate (100%) to determine the Anesthesia Actual Payment Rate at Enhanced Rate. The Anesthesia Actual Payment Rate at Enhanced Rate represents "what the payment would have been" under the enhanced rate structure. Then the Actual Sum of Paid Amount was compared to "what the payment would have been" under the enhanced rates to determine the Payment increase resulting from the rate enhancement:

$230.00 – $112.40 = $117.60

(Projected Payment) – (Actual Payment) = Payment Increase

As with non-anesthesia procedure codes, all projected payments were based upon the percentage of the prevailing rate that was actually paid. In the example, one can follow how different paid amounts and modifiers affect the payment increase calculation.

D. Final Settlements

As our final deliverable, PCG has determined whether the amount of IGT interim payments made by each individual university were adequate to cover the state share portion of the increase in payments due to the rate enhancement, or whether the state had been under or overpaid by the universities. As a result, PCG aggregated the total payment increases for each quarter by each of the three university provider groups, as well as the community providers. All MMIS utilization from this payment reconciliation was broken out for each of four groups based upon Billing Provider Numbers: University of Alabama at Birmingham, University of South Alabama, Children's Health System, and Community Providers. Each group was identified by three lists of billing provider numbers for each of the three university groups. A list of the numbers used for this report can be found under the **Billing Provider Numbers** tab of the Final Report. All billing provider numbers not found on any of the lists for the three university groups were treated as Community Providers.

Final Settlement for Services Provided by University Billing Providers

As part of the agreement to enact the physician rate enhancement, all three universities are required to pay the state-share of the rate increase for their specific providers. The universities have been making interim payments to ALMA for this specific purpose since the enhanced rates were enacted. These interim payments are based upon projected utilization developed by ALMA. As part of this reconciliation, PCG has received information regarding the total IGT interim payments made by each university to pay for the state share of the university enhancement.

The payments for each university's billing providers were attributed only to that university group and only that university was held responsible for its increased payment "gap" as a result of the

rate enhancement. The aggregated quarterly payments that the university received can be found in the **Final Settlement** tab of the Final Report.

Final Settlement for Services Provided by Community Billing Providers

As part of the agreement to enact the physician rate enhancement, all three universities agreed to pay the state-share of the rate increase for the community providers as well. The universities have been making interim payments to ALMA for this purpose since the enhanced rates were enacted. These interim payments are based on projected utilization developed by ALMA. As part of this reconciliation, PCG has received information regarding the total IGT payments made by each individual university to pay for the state share of the community enhancement. PCG has determined the actual payment increase "gap" for all community provider utilization for the dates of service for which these providers have been eligible for the enhanced rates, 1/1/2006-9/30/2006. These community provider payment increases were then apportioned to the three universities based on their percentage of the total payment increases realized across all universities. This calculation can be found in the **Final Settlement** tab of the Final Report binder.

Balance Due

The amount of payment increase each provider received was converted into the appropriate state share for the fiscal year in which the service was provided and then compared to all interim IGT payment that particular university had as of February 25, 2008 made. To each specific university's amount of payment increase, each university's portion of the community payment increase state share was applied. PCG then compared the total payment increase responsibility for that particular university to its total interim IGT payments made to date for the university

enhancement. This amount is then compared to the actual payment increase "gap" to determine if there is an additional amount due or if there has been an overpayment by the universities.